

**Robert A. Moran Jr., DDS, MS and Richard F. Brooks, DDS PA**  
**120 Preston Executive Dr., Suite 100**  
**Cary, North Carolina 27513**

**Authorization to Release Health Information**

Expires upon time of release

Patient information:

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

I authorize Dr. Robert A. Moran Jr. and Dr. Richard F. Brooks, 120 Preston Executive Dr., Suite 100, Cary, NC 27513, to release my or my child's health information.

Please forward/release my health information to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL THE INFORMATION HAS BEEN FORWARDED AS REQUESTED.*

Patient information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to the HIPPA privacy officer: Kelley Ward.

\_\_\_\_\_ Date \_\_\_\_\_

Signature of patient's Personal representative (Parent of legal guardian

\_\_\_\_\_  
(description of Personal Representative's authority)(attach documentation if necessary)